

**MARYLAND
DEPARTMENT OF HEALTH
CENTRAL SERVICES DIVISION
201 W. Preston Street, Baltimore, Maryland 21201**

REPORT

LOST OR DAMAGED MOBILE DEVICE REIMBURSEMENT

User's Name: _____ **Cell Phone #:** _____

Office/Unit: _____ **PCA:** _____ **AOBJ:** 0304

Mobile Device Amount: \$ _____

Accessory Amount: \$ _____

Total: \$ _____

Acknowledgement:

I am aware that it is my responsibility as a user of a State issued cellular telephone to report a lost or damaged mobile device and reimburse the Department for the cost of device and/or accessory. (Ref: MDH-HQ Policy on Cell Phones and Services, effective April 26, 2016).

User's Signature: _____ **Date:** _____

Unit Telecommunications Monitor: _____

Unit Telecommunications Monitor Signature: _____ **Date:** _____

Note: This report and a check must be submitted to Accounts Payable Unit for payment. Payment will not be processed without this report.